Prevention Notes

VA National Center for Health Promotion and Disease Prevention

Winter/Spring/Summer 2002 Veterans Health Administration

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From the Director's Desk—Prevention Strategies

Since our last issue, along with a new VHA administration and VHA re-organization, the NCHPDP has likewise begun its progressive change with a re-organization, staffing losses and new hires, a move to a new location, new phones, and a lot of new ground-level activity. The major change at the NCHPDP is the focus, and we are positively electrified with what it could mean to VA Prevention.

As a quick run down of the Center's accomplishments since DEC 01, we have done the following: obtained funding and launched work on a combined agency VA/CDC flu vaccine toolkit (article in this issue; thx to Kristin Nichol); obtained a grant to fund the ground-work for a VA Weight Management/ Physical Activity initiative; established negotiations for tying into a research/education corporation for administering non-VA funds; started negotiations with AARP for joint cooperation with their "Active for Life" and "Triumph Classic" programs and our Physical Activity initiatives; published the VA Flu Directive; wrote and advertised ten PDs/FDs and went through the screening process of over three dozen potential new-hires; obtained two RWJ Clinical Scholars from UNC to rotate through NCHPDP; joined in the UNC application for VA-RWJ clinical scholars; brought on four HACU summer interns for 10 week projects; began scouring for UNC/Duke doctoral and post-doc students in education, psychology, epidemiology, and marketing; began negotiations for our own VA PrevMed residency program; began the groundwork for establishing a non-physician PrevMed residency program; began negotiations for a Dietitian Master's degree program; began work with Chief Consultant Nursing Services to get a designated Prevention work force in the VA; began serious work putting together the building blocks for an annual VA Prev Med training course for PMPCs; got Public Affairs' approval for Prevention ads on VA pay stubs; began total revision of the NCHPDP website; developed an NCHPDP logo; attended every US Preventive Services Task Force meeting and reviewed and provided input to every recommendation that has come out; joined several teams on the CDC Community-based Preventive Services Task Force, or placed a qualified VA representative on each of the remaining teams; began coordination with DOD-CHPPM for space on their Hooah-4-Health website; participated in the DOD-VA Military and Veterans Health Coordinating Board; began brainstorming with the Army Deputy Surgeon General/Special Assistant for the Army Reserve and National Guard about Prevention initiatives we might begin in the "pre-VA" patient population; wrangled two veterans' question onto the CDC's nationwide Behavioral Risk Factor Surveillance Survey; added a big veteran-oriented slice to CCRC's research grant application to CDC; worked Tobacco-Use-Cessation performance measures and associated issues; attended innumerable national VA and other agency meetings seeking avenues to promote Prevention. Oh, there's more that probably took huge chunks of time, and which were poor pay-offs in time-investment, but which needed to be done.

This laundry list embodies my Prevention battlefield strategy: build an army; gather allies; resource the force; and mount offensives that will thwart the enemy Disease. This is seen in the SIX major NCHPDP goals:

1) Build an NCHPDP workforce and resource the Center - it's difficult to get major projects started when you don't have money or manpower.
2) Build a VA-wide Prevention core/corps that will be Champions for SERIOUS Prevention efforts, not just time-permitting, as-an-afterthought, interventions.
3) Tackle Prevention projects, especially behaviorally-based, Primary Prevention services.
4) Begin our own Prevention Research initiative, focusing on needs and holes in VA Prevention services.

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from the Director's Desk

5) Explore cross-agency cooperation - combine forces, force-multiply, eliminate duplication of efforts, and capitalize on what others are already doing!

6) Meanwhile keep all those other Prevention things spinning, like representation on the USPSTF, the CDC's Community Based PSTF, CPG Advisory Council, Performance Measures Work Groups, EES cooperatives, DOD Prevention liaison.

Why this battle plan? The NCHPDP has a Congressional mandate of "All Things Prevention" for the VA, giving it a mission similar to the DOD CHPPM or the HHS CDC - to bring a strategic focus to Prevention in the VA, as would be expected for a health care organization that boasts being the largest in the United States. Good Prevention strategies identify the biggest targets that can impact the greatest number of diseases and benefit the most people. The three most lucrative targets for Prevention revolve around Behavior:

1) weight management/physical activity;
2) tobacco use; and
3) drug and alcohol abuse.

Treatments for these three are based on behavioral modification—not medications (although medications may play a supportive role in behavioral change.) The number of disease processes resultant from these Big Three correlate with continual and increasing medical costs, and with increasing decline in patients' Quality of Life.

The logic of a Behavioral Prevention strategy is demonstrated with a military analogy. Modern Militaries do not wait for their soldiers/sailors/airmen to come into the hospital with war wounds; instead they try to PREVENT the wounds - for instance, by using body armor, advanced weaponry, and combat training. In the same way, we have to give the vets "disease-armor" and "disease-weapons", and show them how to dodge "disease-bullets", so that we can keep them healthy and disease-free. This is the job of Primary Prevention - "get to them BEFORE they're sick." Stop the behavior that causes the health risk BEFORE it becomes a disease: tobacco cessation, weight loss, physical activity, alcohol/drug abuse cessation, and other obvious measures that amount to plain, sensible living. Tackle the head of the salamander, don't chase the tail! Once patients have the disease (like hypertension, heart disease, diabetes, arthritis, etc.), it is probably a safe generalization to say that the pathology will only progressively worsen, and they will require treatment for that disease for the rest of their lives.

While this makes absolute sense, it just isn't that easy. The human mind is so complicated and individualized that it makes behavior modification a very difficult process. That's why it requires a concerted, dedicated, and supported effort to seriously address Prevention problems - but it's still better (and cheaper!) than waiting to treat disease.

One of our major aims at the NCHPDP will be to seek ways to make Prevention into an integral and substantial part of the total health service package for our veterans. There is no doubt that what the VA health care organization is doing NOW is being critically looked upon as a pattern for the rest of the health care industry in the United States in the years to come. Establishing the importance of Prevention now, as a key component of health care in the VA, makes the absolute best sense in terms of Quality of Life, economics, and health - and helps identify the VA as a Leader in tackling health care as a total service. It won't be easy, but it is RIGHT!

Too much to do? Too big a burden? You bet! We wouldn't want it any other way! Just ask Connie, Eileen, Pam, Rich, Susi, Mike - and Mary. GoGoGo.

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Center Welcomes New Staff

Over the past eight months the National Center for Health Promotion and Disease Prevention (NCHPDP) has not only undergone a myriad of activities but has also successfully recruited five new staff members. We are very excited about the skills and talents this group brings to the NCHPDP. Both their individual and combined knowledge and experiences will move the Center forward in accomplishing our objectives of promoting healthy lifestyles and preventing disease in our nations veterans. The Center graciously welcomes:

Susi K. Lewis, RN, MA
Eileen Ciesco, MHA
Richard Harvey, PhD
Mikeal Harrelson
Rosemary C. Strickland, RN, MSN, CS

To learn more about these new staff members and all of the NCHPDP staff, visit our website at **vaww.nchpdp.va.med.gov** and click on "The Center and Staff".

Congratulations! Retirements from the NCHPDP

While we are glad to bring on new staff to the Center we are sad to see dedicated employees leave. We wish them well and praise them for their commitment and service to out Nation's Veterans:

Dorothy R. Gagnier, PhD, Assistant Director, Education — 17 years of service in the VA

Ron W. Sorrell, Administrative Officer — 28 years of service in VA

Availability of Weight Management Programs in the VA

Mary Burdick, PhD, RN, Chief of Staff, NCHPDP

With obesity prevalence climbing precipitously from 13 to 26% of adult Americans over the last 4 decades, obesity is increasingly recognized as a major health concern for the nation. It has been linked with increased mortality as well as substantial morbidity — including increased risk of heart disease, stroke, certain cancers, and diabetes — as well as limited function and marked social stigma. Several large evidence-based systematic reviews have recommended clinical attention to body weight — including the US Preventive Services Task Force, the Canadian Preventive Services Task Force, Britain's National Health Service, and an expert panel from the NIH. The US Surgeon General has released a "Call to Action" for combating overweight and obesity. As the health care provider to a national population of veterans, the VA is in a unique position to meet this challenge, addressing body weight from both a clinical and public health perspective.

In 1996, the VA National Center for Health Promotion and Disease Prevention (NCHPDP) recommended that 100% of VHA facilities should have formal nutrition counseling and/or education available for weight control for outpatients (VHA Handbook 1101.8), including assessment of body mass index (BMI = kg of weight/meters of height squared). The NCHPDP recommended that primary care clinicians encourage all patients to engage in a program of physical activity and fitness tailored to their health status and personal life style. In May, 1999, the revised preventive medicine VHA Handbook (1120.2) recommended that all veterans should receive height and weight measurements (BMI) every two years and counseling for maintaining healthy body weight. Specifically, all veterans should have access to counseling to limit dietary intake of cholesterol, maintain caloric balance and emphasize foods containing fiber. Female veterans should be advised to consume adequate amounts of calcium. In addition, all veterans should be encouraged annually to engage in physical activity tailored to their health status and personal lifestyle and have access to counseling regarding optimizing their level of physical activity.

Despite these recommendations, excess body weight is extremely prevalent among veterans. As a first step in addressing this issue more aggressively, the NCHPDP disseminated a query to the Preventive Medicine Program Coordinators (PMPC) in June, 2001, regarding clinical programs designed to promote healthy weight in veterans. The findings were presented at the Ambulatory Care Meeting, August 27-30, 2001.

Program Availability:

The NCHPDP received a 71% response rate from 151 PMPCs. Some PMPCs reported for two or more facilities within their healthcare system. Responses indicated that there were only 42 weight management programs for veterans within VA nationwide. The term "program" was widely interpreted, ranging from simple dietary referrals to more intensive, multidisciplinary programs with follow-up.

Program Components:

Thirty-nine programs reported which disciplines were responsible for their programs. Of these, 67% identified dieticians; 12 programs reported being run by a psychologist; physicians, nurses and other providers infrequently led programs; 19% were social workers, pharmacists or diabetic educators.

Common drugs used for the treatment of weight management are Xenical, Meridia, and Fastin. Only two facilities reported Xenical available on formulary; some facilities reported that Xenical and Meridia are restricted, non-formulary items. Others reported that medications were non-formulary, but could be obtained with approval from Chief of Staff.

"Does your program have a specific number of sessions?" The number of sessions ranges from "ongoing weekly" to "12 week" programs. The Minneapolis VAMC has a 2-week inpatient intensive program with follow-up indefinitely after discharge. Programs that are fairly intensive are rare, but were reported at some sites such as San Francisco, Little Rock and Tampa VAMCs.

Program Longevity:

"How many years has your site had a weight management program?" Survey results indicate that weight programs have been in existence from "1 month" to "15 years". Several weight management programs started this year with a fairly simple format while others that have been existence for many years may have a more sophisticated format (e.g., one site has a four-tiered program that includes education, weight loss/fitness class, individual counseling, and a 10-week program for higher risk/higher weight/higher motivated veterans).

Meeting the Surgeon General's Call to Action

The fact that individual health centers had developed weight management programs on their own initiative is encouraging in the face of the difficult issue of weight management. However, in the setting of epidemic prevalence trends, the presence of programs in less than half of VA hospitals is clearly inadequate. In addition, the broad definition of "program" by PMPC respondents may over-represent access to effective weight control measures; people with extreme weight problems may require intensive intervention to achieve sufficient sustained weight loss to improve health outcomes. It is important to note that weight management is a complex issue which many primary care providers have little subject matter knowledge and experience; effective dissemination and coordination of information and resources may be critical in developing a useful weight management program. Providers with specialized training in counseling to promote behavioral change are needed. Given the potential for substantial prevention of disease and disability, NCHPDP has made overweight and inactivity one of its top priorities and will continue to recommend national changes to improve the delivery of effective services in weight management programs. Several efforts currently are in various stages of action/planning at the NCHPDP regarding

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the VHA Weight Management Initiative - so stay tuned. We want to reach the still-healthy veteran BEFORE she/he comes to our medical facilities with the pathology.The NCHPDP would like to thank all the PMPC who participated in this survey. If you would like to be added to the Weight Management email distribution list, please contact either Connie Lewis or Susi Lewis, both are on Outlook.

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The "Battle of the Bulge": Hope in the War Against Obesity

Dawn William Clifford, RD, Carl T. Hayden VA Medical Center

If losing weight and keeping it off were easy, I would be out of a job. I never fear this happening however, because the obesity epidemic continues to explode and dieting is never easy. The word "diet" has become another 4-letter word. Sixty-six percent of Americans are overweight or obese. Billions of dollars are spent each year on a wide array of weight loss pills, books, and videos. All the while, Americans are losing the war against obesity.

As a dietitian, I work on the front lines of this battle. With super-sized meal deals, big gulps, and Little Debbie's, the opposition stands tall. After a long hard day at the office, a short wait at a drive-through window and a nice nap on the couch are all too inviting.

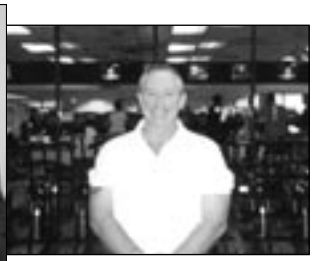
As bleak as the picture may seem, veteran dieters take heart--everyday men, women, and children are winning their own private dieting battles.

Mr. Costello at 350 lbs. before beginning weight loss program (pictured with nephew)

One Veteran's Experience

Meet William "Butch" Costello. As a veteran of the United States Army, Butch is also a survivor of the "Battle of the Bulge." At age 43 Butch weighed 350 pounds, and was in desperate need of a push toward the front lines. Life was not easy for Costello. "Getting the seat belt on was almost physically impossible," he said. "I couldn't walk to my car without taking a breather. If I got groceries, it was a major event." For a while, these small inconveniences were worth the benefits of overeating. It wasn't until Costello was diagnosed with diabetes that the battle lines were clearly drawn.

His first strategic move was a drive to the Carl T. Hayden VA Medical Center in Phoenix, Arizona. Costello recalls, "I gave up my well-paying job in sales and moved back home to Phoenix to take care of my health." With a body fat content of 49%, Costello was also facing an umbilical hernia, injured knees, sleep apnea, neuropathy, high blood pressure, high cholesterol and diabetes. "I literally thought that I was going to die," he recalls.



Top...Costello at 200 lbs.
Left.. With Dietian Dawn Williams Cliffford, June 2001 after achieving weight goal

Weight Loss 101

There are hundreds of diet books out on the market with new theories about "the latest and most effective weight loss techniques." However, research has proven over and over again that weight loss is all about the big "C"-- CALORIES. It doesn't matter if you eat at night, or in the morning, on your head or sitting down; to lose weight you must consume fewer calories than you burn.

Finding out the number of calories you are currently eating is the first step toward losing weight. At Costello's first meeting with his clinical dietitian, she discovered he was munching away close to 3,500 calories a day. The next step to weight loss is to log in every bite of food and gulp of beverage consumed for a few days. Beside each item consumed, write down the number of calories contained in that food or beverage. This information can be found on food labels, calorie counting books, or calorie counting websites. Add up the number of calories you are consuming per day on average, and subtract 300-500 calories from that number. For the next few weeks eat within the new calorie range. For example, Costello was eating 3500 calories a day. We subtracted 300-500 calories from that number, and he was left with 3000-3200 calories a day as a goal range. A registered dietitian can help you find ways to subtract calories from your diet that are practical and healthy. Gradually the number of calories consumed is reduced.

The idea is to keep your body from actually knowing you are on a diet. When your body begins to lose weight too quickly, metabolism slows down as a safety mechanism against starvation. Making small calorie deductions can lead to a gradual weight loss without causing extreme hunger.

Next, find ways to increase the number of calories burned throughout the day. Different exercise plans work for different people. If you are a person who works best with a schedule, try planning an evening walk 5-6 nights a week after dinner. If you feel you don't have time to set aside for exercise, try increasing the calories you burn by taking the stairs at work, or parking in the farthest parking spot from your destination. Your goal is to simply burn more calories during the day than you were previously burning.

Monitor your weight with a scale and a tape measure. A healthy weight loss rate is 0.5 to 2 pounds per week. Your calories or exercise regimen may need adjusting as you continue to lose weight. Start out with a short-term weight loss goal of losing just 10% of your current weight. Meet with a registered dietitian to determine a healthy, long-term weight loss goal. Costello tracked his weight on a graph, and looked forward to his monthly visits with his dietitian so that he could chart his new weight.

Costello kept food records for two years and in June of 2001 reached his goal weight of 200 pounds. In addition to dietary and medical services, Costello also received help from medical psychologists and exercise therapists at the Carl T. Hayden VA Medical Center. Losing weight is a team effort. Nobody fights a battle alone. Weight management requires the assistance of family, friends, and a team of health care providers.

Costello won his battle. Now we work together side-by-side on the front lines. As our weight loss hero at the Carl T. Hayden VA Medical Center, Costello became a volunteer member of our health care team and is a regular speaker at the weight management and diabetes classes. Weight maintenance is his new passion and Costello realizes that he must dedicate himself to continue regular exercise and calorie control. He agrees-- the price is worth the gain of an improved and longer life.

With the help of a VA Health Care Team, this battle was won. Maybe the war against obesity is fought with one person at a time and each battle begins with one calorie at a time.

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The Obesity and Overweight Challenge In the VHA: Where Do We Stand?

Overweight and obesity have become a national epidemic. An estimated 60 percent of adult Americans are obese or overweight. And if that's not enough, the number of people who are obese has increased by more than one-third in the last 20 years. Americans spend more than $34 billion a year for weight-loss products and services. In many cases, they get no long-term benefit for their investment. In the September 2001 issue of JAMA, Mokdad et. al. noted obesity not only increases morbidity and impairs the quality of life but, that the direct costs of obesity and physical inactivity account for approximately 9% of U.S. Healthcare expenditures.

Since weight management is so difficult, it is not surprising that individuals tend to look for a quick- fix. However, overweight and obesity are complex problems, complicated by genetic, environmental and emotional issues. Chances are, unless an individual is able to make a long-term lifestyle change to alter their eating habits in sustainable ways, and become more physically active, weight will gradually increase with age and after each weight-loss attempt.

Incidence

Within the VHA, obesity and overweight are significant health care problems and the prevalence in the study areas appears to be even higher than that seen in the general population (see table below). Veteran patients also have substantial numbers of co-morbidities that increase their overall risk of disease and health complications.

Survey	Sample Size	Overweight (BMI ≥ 25)	Obese (BMI ≥ 30)	Extreme Obesity (BMI ≥ 40)
BRFSS, 2000 (1)	184,450	56.4%	19.8%	2.1%
NHANES, 1988-94 (2)	30,000	54.6%	22.6%	n/a
Veterans, Medical Practice Clinic Sample (3)	2,260	69%	29%	4%
Veterans, Specialty Clinic Sample (4)	1,731	75%	34%	4%
Veterans, CBOC Self Assessment Survey (5)	303	n/a	24%	n/a

(1) From the Behavioral Risk Factor Surveillance System, a cross-sectional telephone survey conducted by Center for Disease Control and Prevention and state health departments. The data is a representative sample of adults (> 18 years) with BMI calculated based on self-reported weight and height.
(2) From the National Health and Nutrition Examination Survey, a representative U.S. sample, height and weight are measured and BMI calculated.
(3) Statistical review of patients seen the month of October 2001 in the San Francisco VAMC Medical Practice Clinics. BMI was calculated based on data entered into the VISTA vital signs package. Height and weight are measured; weight is without shoes and jackets.
(4) Data from Minneapolis VAMC survey of a cross section of 7 specialty clinics. Height and weight were measured and BMI calculated.
(5) Self reported data from an "Assessing Your Health Risk Survey" completed by Community Based Outpatient Clinic patients in northern California in July 2001. Number of veterans who responded that they were "more than 30 pounds over weight" was included in the BMI > 30 category.

Perhaps one explanation for the higher levels of obesity among veterans is that the majority of the veteran data is more recent (2001) as compared to earlier general population data, and is based on measured height and weight. Validation studies of self-reported data have shown overweight individuals tend to underestimate their weight and all persons tend to overestimate their height. However, even a small self-reported data sample from 303 veterans, indicated obesity levels higher among veterans than the self-reported general population. Contributing factors to this higher obesity level may be related to the age ranges, educational levels and ethnic backgrounds observed in the veteran population. The Behavioral Risk Factor Surveillance System (BRFSS) survey included a review of characteristics seen in individuals with higher levels of obesity and found greater obesity among individuals between the ages of 40-69, having high school or less educational levels, and from Black and Hispanic heritage. Other compounding factors in the veteran population may be related to the fact that many do not have an active family support system, or their

living arrangements may not be conducive to home prepared meals. Many may be taking psychotropic or other medications that promote weight gain, or have limitations on physical activity secondary to other medical conditions.

Intervention Strategies

Successful weight loss, and even weight maintenance as individuals age, is a significant challenge and generally requires a life-long effort. In 1998, the National Heart, Lung, and Blood Pressure Institute (NHLBI) developed evidenced-based Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (available at www.nhlbi.nih.gov). The impetus behind development of these guidelines was the increasing prevalence of overweight and obesity in the United States and the need to alert practitioners to the accompanying health risks of this condition.

Treatment of an overweight or obese person incorporates a two-step process: assessment and management. Assessment includes determination of the degree of obesity and overall health status. Management involves not only weight loss and maintenance of a healthy body weight, but also, measures to control other risk factors. Obesity is a chronic disease. Patient and practitioner must understand that successful treatment requires a continuous effort. Convincing evidence supports the benefit of weight loss for reducing blood pressure, lowering blood glucose and improving dyslipidemias.

Assessment

Assessment includes reviewing a patient's body mass index (BMI) to determine the extent of the obesity in conjunction with a review of other risk factors or co-morbidities. The BMI measure is the ratio of weight to height squared (wt/ht2) and is more highly correlated to body fat than any other indicator of height and weight. Individuals with a BMI greater than 25 are considered overweight, and those with a BMI greater than 30, obese. Those with a BMI greater than 40 are considered extremely obese. Typically, weight loss therapy is recommended for patients with a BMI greater than 30 and for patients with a BMI between 25-29.9 with two or more risk factors.

Management

The decision to attempt weight loss should begin with a candid discussion of risks between the health care professional and the patient, advising him/her of the importance of weight loss and stressing the benefits of healthy weight. Mokdad et. al. reported that persons who receive advice from health care professionals are more likely to lose weight. However, in the BRFSS survey, only 15.6% of overweight participants had received such advice. Thus, the initial first step for all providers is to assess overweight/obesity risks and start discussing it with their patients. The next step would be recommending weight loss and/or prevention of weight gain, based on the individual needs of the patient.

The initial goal of weight loss therapy for overweight patients is a reduction in body weight of about 10 percent. Further weight loss can be considered after this initial goal is achieved and maintained for 6 months. The rationale for the initial 10 percent goal is that a moderate weight loss of this magnitude can significantly decrease the severity of obesity-associated risk factors. It is better to maintain a moderate weight loss over a prolonged period of time than to regain weight from a marked weight loss.

Effective weight control involves an interdisciplinary approach with multiple techniques and strategies including dietary therapy, physical activity, behavioral therapy and/or a combination of all three. Pharmacotherapy and surgical options are also used for patients with high levels of BMI and co-morbidities. In some patients, weight loss is not achievable. The goal for these patients should be prevention of further weight gain, which would exacerbate disease. Some patients benefit more from weight management programs primarily geared for the prevention of weight gain, than for weight loss.

The majority of VA Medical Centers have Nutrition Clinics available for weight loss/management referrals. These Clinics are staffed by registered dietitians and offer individual counseling/education and group classes. Some of the clinics have specialty weight loss, and interdisciplinary programs that are typically 6-10 weeks in duration. Dietitians, psychologists, nurses, and physical therapists teach the sessions. Once the need for weight loss is identified, veterans should be referred to the nearest VA Nutrition Clinic for weight loss counseling and ongoing follow-up. For more severe cases of obesity, referrals may be made to Medical Centers that offer bariatric surgery.

Successful VHA Strategies

Patient weight loss and maintenance are extremely difficult. An assessment of a patient's "Readiness to Lose Weight" can be of great assistance. Information concerning previous weight loss attempts; the type of support available from family/friends; the patient's attitude toward and ability for physical activity; motivational level; and a complete understanding of the health risks involved is necessary from the start. Potential barriers such as one's living situation and financial status should also be considered. Once there is a thorough understanding of the patient's situation, designing an individualized plan to meet his/her needs is key.

Patient involvement and investment are also crucial to success in the weight loss process. Setting achievable goals, establishing small steps (behavior changes related to both diet and activities/exercise) to achieve between appointments, monitoring progress and providing ongoing support are critical in attaining realistic goals.

At the San Francisco VAMC, nutrition education guidelines and referral triggers define an interdisciplinary approach to weight loss intervention. Patients scheduled in the nutrition clinic complete a self-assessment "Readiness To Change" questionnaire and actively participate in the development of their own individual goals. Nutrition Clinic outcome monitors have found that patients who are most successful in losing weight are those who are able to make two or more behavior changes between follow up visits. Typically, there are between 1-3 follow up visits scheduled, depending on individual patient needs and progress.

The Minneapolis VAMC incorporates a "learn by doing" approach to changing food and activity choices. Patients are admitted for a two-week program involving a low calorie diet, supervised exercise, and daily classes. Follow-up after the program provides ongoing group support sessions as well as individual meetings with

physicians and dietitians that function as problem-solving sessions where veterans are able to discuss and agree on plans to combat their struggles. Other programs available include a 10-week behavior modification program consisting of diet education, fitness and behavior change. The key to long-term success with these programs is ongoing healthcare staff support and follow-up after the program has been completed.

Conclusion

Clinicians play a key role in the identification of risk, goal setting and facilitating patient success with various weight loss and management interventions. Active discussions, referrals, and ongoing support of the patient's progress are essential in the implementation of successful weight loss programs. In subsequent editions of "Prevention Notes" the authors of this article will highlight some successful VA programs and strategies as examples for meeting the ongoing challenge of obesity and overweight problems in the current veteran population.

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Influenza/Pneumococcal Resource Toolkit Development Team

The VA National Center Health Promotion/Disease Prevention (NCHPDP) and Dr. Kristin Nichol at the Minneapolis VA developed a collaboration with the Centers for Disease Control and Prevention (CDC) for a demonstration project aimed at increasing rates of influenza and pneumococcal vaccinations among veterans. An initial survey assessment of current practices in the VA has been completed. On July 15, 02, the following volunteers from VAMC's throughout the nation met at the VA NCHPDP in Durham, North Carolina:

Molly Aldassy (Seattle)
Mary Burdick (NCHPDP)
Isabel Duff (Prescott)
Joan Foley (Honolulu)
Sharon Kelly (Baltimore)
Susi Lewis (NCHPDP)
Sherry Peters (Jackson)
Rosemary Strickland (Durham)
Geraldine Weiss (Rochester)
Karen Allen (White City)
Linda Danko (Cincinnati)
Eileen Ciesco (NCHPDP)
Joyce Frederick (Durham)
Connie Lewis (NCHPDP)
Terri Murphy (Durham) guest
Rose Mary Pries (St.Louis)
Susan Sucharski (Erie)
Steven Yevich (NCHPDP)

The highly motivated and dedicated team worked non-stop for 2 1/2 days. Working lunches were the norm as the energetic team members wanted to keep the momentum. The participants, who were divided into smaller work teams, were very productive and completed many Toolkit deliverables. The combination of a hard working, driven group of individuals (many of whom will directly benefit from the materials provided by the toolkit) with a supportive work environment (the National Center staff responded to all the groups' needs) facilitated the efficiency of the team. The enthusiasm and energy continues in weekly conference calls devoted to refinement of toolkit contents.

The overall goal is to develop a generic, high-quality, ready-to-use toolkit, that includes a local and national advertisement campaign, to be distributed as a resource. The anticipated outcome of the project is to increase influenza and pneumococcal vaccination rates among the veteran population, and improve health and quality of life.

Final Toolkit Contents will be selected from the following:

- flu bug logo
- sample policies/protocol templates and checklists
- listing of related resources/websites
- sample flyers, information handouts, view alerts
- provider/staff education & reminders
- marketing for earnings and leave statement
- review/selection of flu video
- patient reminders, mailed and telephone
- CDC resources
- local campaign materials - posters/buttons/stickers
- patient health education materials
- news release articles
- powerpoint presentation
- CD ROM of all printed materials
- evaluation (of the toolkit)
- evaluation question's for patient satisfaction survey

Left to right: Sue Sucharski, Molly Aldassy, Rosemary Strickland, Sharon Kelley

Special Recognition is extended to the following individuals:

Team Advisors
Dr. Serigne Ndiaye (CDC)
Dr. Kristin Nichol (VHA)
Dr. Gary Roselle (VHA)

Field Participants
Meri Hague (Minneapolis)
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Team Advisors provide expert advise/consultation; Field Participants participate via weekly conference calls; Employee Education System assist with program logistics, travel and budget.

A special thanks is also extended to the entire NCHPDP staff, who provided support during the preparation phase and meeting days.

The team believes the materials will be available in the VAMC's and CBOC's in time for the 2002-03 flu season. Additional toolkit information and updates will be forthcoming. Remember: protect yourself, your patients, and your family members by getting the influenza vaccination this fall!

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Top Photo: Geraldine Weiss, Joan Foley, Joyce Frederick, and Karen Allen

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Colorectal Cancer Screening

In July, 2002, the U.S. Preventive Services Task Force reconfirmed their strong recommendation that all adults older than 50 years of age should be screened for colorectal cancer (http: //www.ahcpr.gov/clinic/3rduspstf/colorectal/) The Task Force recommended the following strategies for screening:

- Yearly screening with fecal occult blood testing is supported by well-conducted randomized trials showing a 33% reduction in colorectal cancer deaths after 13 years. While a single FOBT is insensitive, a program of repeated annual testing can detect as many as 92% of cancers.
- FOBT followed by flexible sigmoidoscopy or flexible sigmoidoscopy alone every five years are supported by case-control studies, but not by randomized trials.
- Colonoscopy recently has been advocated for screening, usually at 10-year intervals or as a once-in-a-lifetime examination at age 55-65. The estimated sensitivity of a single colonoscopic exam is 90 percent for large polyps and 75 percent for small polyps (less than 1 cm). No controlled trials of screening with colonoscopy have been done to determine the balance of benefits against harms in screening average-risk patients.
- None of these recommended screening strategies is clearly more cost-effective or acceptable to patients than the others.
- The effectiveness of screening with a barium enema or with CT colography is unclear. These approaches are not recommended.

Dr. Mark Helfand, Portland VAMC, has worked closely with the USPSTF for the past 4 years as a science advisor Som Saha, MD, also at the Portland VAMC, was a co-author on the USPSTF report on the cost-effectiveness of the different screening strategies (in Ann Intern Med 2002;137(2):96-104, also available at http://www.ahcpr.gov/clinic/3rduspstf/colorectal/colocost1.htm.)

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Barriers to Effective Tobacco Use Cessation Program Implementation:

Results of an NCHPDP Survey of VHA Facilities

Smoking continues to be the leading cause of preventable death in the United States. Overall, it led to approximately 440.000 premature deaths annually from 1995 through 1999, with an average loss of life of 13.2 years in adult male and 14.5 years in adult female smokers (CDC, MMWR 2002; 51(14): 300-03). Over the same time period, a staggering $81.9 billion, on average, was lost annually in productivity due to smoking-related death. In 1998, smoking-attributable personal health-care medical expenditures were an additional $75.5 billion, according to CDC figures. These numbers represent a substantial increase over prior estimates of $53 billion and $43 billion, respectively (MMWR 2002; 51(14): 300-03).

Reducing tobacco-related morbidity and death is a high priority for the Veterans' Health Administration (VHA). Smoking rates among veterans exceed national averages, and smoking continues to pose a substantial threat to veterans' health. Smoking more than one pack of cigarettes per day, considered a principal indicator of tobacco addiction, is more than twice as prevalent among VHA enrollees as among the general U.S. population, according to the findings of the 1999 Large Health Survey of VHA Enrollees (December 2001, Office of Quality and Performance, Veterans Health Administration). Despite a national effort to make effective tobacco-use cessation (TUC) programs available to VA enrollees, many veterans who use tobacco never receive these services.

As a step towards increasing the effectiveness of tobacco cessation efforts the VA National Center for Health Promotion and Disease Prevention (NCHPDP) surveyed Preventive Medicine Program Coordinators (PMPCs) at all VA Medical Centers (N=151) regarding description of existing programs perceived barriers to intervention. The survey was administered in July, 2001, with a 61% (92) response rate of the national sample.

Table 1. VA Tobacco Use Cessation Programs Query Summary (61% response rate)

TUC programs are conducted within:	Referral clinics only	67%
	Integrated within primary care	4%
	Combination of above	28%
Involvement of Behavioral/ MH staff:	Direct involvement in treating patients	63%
	No involvement	10%
	Referral for mental disorders (PTSD, depression, etc.)	43%
Availability of recommended medications:	Nicotine patch	91%
	Nicotine gum	34%
	Nicotine nasal spray	5%
	Nicotine oral inhaler	4%
	Bupropion (Zyban®)	58%
	Bupropion (Wellbutrin®)	54%

Current Programs

A number of questions described existing TUC programs (Table 1). The TUC programs were conducted predominantly as referral clinics. The extent of involvement of behavioral or mental health staff in the stop smoking programs varied across sites. Slightly more than half of the reporting programs indicated direct involvement of behavioral or mental health staff in treating patients, while fewer than one half utilized behavioral or mental health staff for referral for patients with depression, anxiety, PTSD, psychosis, and 10% reported having no relationship whatsoever with behavioral health services. Over 90% of sites recommended nicotine patch use for the treatment of veterans with nicotine dependence; other modes of pharmacotherapy were not consistently available across sites.

Potential for Improvement

An overwhelming majority of respondents felt that there was room for improvement in their VA TUC program (94%). When asked, "What do you think keeps you from achieving the most effective program for nicotine dependence treatment at your VAMC?" the top five barriers reported by PMPCs were (most common listed first):

- Poor "show" rates
- Medications restricted to patients who attend behavioral treatment program
- Lack of sufficient staff to conduct TUC program
- Prescribing of medications restricted to a few physicians rather than all primary care physicians
- Difficult to get nicotine replacement therapy and bupropion for patients.

Additional barriers reported to be of significance in the failure of TUC efforts to reach more veterans in need of these services were:

- Out-of-pocket expense too high to attend counseling sessions;
- Poor follow-up with patients after 1st session;
- Absence of a "champion" to advocate for tobacco cessation resources;
- No incentives;
- No hand-held CO2 monitors;
- TUC program not high priority at facility;
- Beliefs among staff that "patients only quit on their own when they are ready and that the TUC program does not make much difference";
- Patients who work are unable to attend week-day sessions;
- Distance/time patients have to travel to attend sessions.

Several other identified barriers can potentially be addressed through relatively simple system-level change. Respondents report that when veterans are identified who could benefit from pharmacotherapy, it is both difficult to obtain appropriate prescriptions, and difficult to have them filled in a timely manner. Changes in pharmacy protocols or prescriber authority could ease these barriers substantially, such as immediate availability of medication rather than waiting for mailed prescriptions.

Responses indicate that low attendance is a major problem at behavioral treatment programs - but also point towards some possible reasons for this deficit. If veterans cannot attend sessions due to cost, timing, or location, these interventions have no hope of effectiveness. It is critical that we respond quickly to engage the veteran when he/she indicates a willingness to engage - "same day response" is ideal. Availability of trained staff at the right time is critical. One solution may be to incorporate approaches, such as telephone-based interventions, tailored mailings, videoconferences or web-based communication. Another is to increase funding resources for the VA to reduce direct patient costs and expand staffing so that more flexible scheduling can be achieved, including initiating more classes in the evening and at other more convenient times and locations. A third is to establish VA partnerships with local community resources, such as state health departments.

Finally, it is of concern that a number of respondents cited negative attitudes towards TUC within the VA, "a low administrative priority level to the initiative" and "the TUC program does not make much of a difference". As noted above, tobacco use carries a major health and financial burden among veterans. The TUC programs have been proven to be successful as well as cost-effective in clinical settings. As the country's largest healthcare organization with a greater average of tobacco users, the VA needs to work to increase the importance of cessation.

The NCHPDP stresses that medications without behavioral treatment should not replace the combined approach entirely (use of the two together has been shown to be more effective than either alone) — but is meant to provide some sort of tobacco cessation support for those whose remote location or other circumstances prohibit attending behavioral sessions. The importance of expert behavioral interventions in an individual's successful recovery from tobacco dependence has been well established. It is well documented that the highest rates of success are found in programs that utilize behavioral counseling in conjunction with medications.

VA providers are one of the systems greatest resources — having direct contact with patients, first-hand knowledge of system mechanisms, and dedication to quality healthcare. Those surveyed here offered a number of possible innovations to improve tobacco cessations within the VA, including:

- Set smoking cessation as a VHA priority with dedicated funding for full implementation of effective programs — make it a national initiative similar to Hepatitis C;
- Smoke-free workers; staff education about TUC; insist that health care workers who smoke become role-models and enroll in a TUC program;
- Same day interventions available at point of care; remove patient waiting time for treatment;
- Remove restrictions for NRT and bupropion -- inexpensive and available on the spot;
- Educate decision-makers that TUC programs are cost-saving compared to other more commonly provided services;
- Need to designate a VISN coordinator for tobacco use control;
- Have a national standardized training that endorses a united VA approach based on up-to-date literature targeting all disciplines and staff levels;
- VHA approved and centrally available TUC promotional and educational materials; signage for clinic areas, etc.;
- Free TUC treatment for smokers' spouses;
- Remove barriers to access to TUC program;
- Outlaw smoking on VHA property.

The NCHPDP has made tobacco use cessation a high priority and will continue to recommend national changes to improve the delivery of effective services in tobacco use cessation programs throughout the VHA. We will assist all efforts to ensure that veterans who express interest in quitting receive same-day treatment with appropriate follow-ups.

The VHA Handbook 1120.2 recommends "all veterans should be screened annually for tobacco use, and counseling offered to those who use tobacco." The United States Community Preventive Services Task Force recommends four evidence-based health care system-level interventions:

1) reduced out-of-pocket expenses;
2) patient telephone support;
3) provider reminders; and
4) combined provider reminders and education of both providers and patients (MMWR Reports and Recommendations, November 10, 2000/Vol. 49/ No.RR-12).

The VHA/DOD Tobacco Use Cessation Clinical Practice Guidelines detail clinical guidance for program development. As one of the largest health care systems in the country, with a disproportionate burden of tobacco-related disease, the VA should be a leader in implementing these recommendations.

The NCHPDP is optimistic that as part of an evolving culture of health care in the VHA - every veteran tobacco user will have access to effective treatments for tobacco dependence. We appreciate the responses from the PMPCs and expect their ideas will be used in recommending national changes for improving the delivery of QUIT SMOKING programs. Veterans and VHA staff deserve no less.

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Pre-pregnancy Smoking Cessation Counseling:

Strategies for the VHA Primary Care Clinician

Skills in pre-conception counseling are essential for primary care providers, particularly now that the standard benefits package for veterans includes prenatal care. All women who have the potential to become pregnant are candidates for pre-conception care.

Fifty percent of all pregnancies in the United States are unplanned. It is important to address pre-conceptual counseling in women who are not planning a pregnancy as well as those who are. Organogenesis occurs between days 17-56 following conception and many women are not aware that they are pregnant during this critical period. How do the approved additions to the health care benefits package affect women veterans and how can we as healthcare providers in the primary care setting maximize the wellness of the woman and child?




Left to Right: Stacey I. Kaltman, PhD, Melanie E. Bennett, PhD, Andrea S. Van Horn, CNP, BSN, Catherine A. Staropolie, MD

Since 19-30% of pregnant women smoke and it is estimated that 10% of perinatal mortality is attributed to smoking, primary care providers need to address the issue of smoking cessation prior to the occurrence of pregnancy. For those trying to become pregnant, it is important to discuss the negative effect that smoking may have on fertility rates. Additionally, tobacco use has been associated with low birth weight, spontaneous abortion, placental rupture, preterm delivery, and sudden infant death syndrome.

Brief tobacco cessation interventions in primary care can make a difference. A primary care provider sees 70% of smokers. Given this level of access, primary care clinics provide an ideal setting for reaching smokers and providing smoking cessation interventions. Minimal interventions, as simple as physicians advising their patients to quit smoking, can produce cessation rates that are 2% to 5% greater than no intervention at all. More intensive interventions, including counseling and pharmacologic treatment, can raise quit rates to between 20% and 25%. Overall the literature shows that a continuum of interventions, from the most brief to the more extended, can have an impact on smoking cessation with patients.

The literature in this area can be organized around the two most frequently found types of strategies: simple advice to quit and brief interventions delivered by physicians and other primary care personnel. Both advice and interventions have been found to yield increased rates of smoking cessation. In an influential review, Kottke and colleagues estimated that counseling smokers to quit in primary care settings achieved long-term abstinence rates of between 5 and 10%, while more intensive similar interventions produced rates between 15% and 30%.

For many smokers, advice is equal to treatment and is all that is needed to inspire quitting. A doctor's recommendation to a patient makes a difference. Russell and colleagues did one of the earliest studies of the effects of a physician's advice against smoking in 1979. They assigned over 2,000 smokers attending primary care clinics to one of three groups: no intervention with assessment only; simple advice by a physician to quit; and, advice from a physician plus a pamphlet. All groups received a follow-up assessment as a post test. The proportion in these groups who were not smoking after one year were 0.3% in the control group, 3.3% in the advice only group, and 5.1% in the advice plus pamphlet group. Since greater than 80% of the population visits a healthcare professional, usually in primary care at least once per year, such rates could translate into substantial increases in quit rates if advice was applied systematically across the country.

Another study (Demer et al) randomly assigned smokers from two family practices in Michigan to routine care or a 3-5 minute unstructured, physician-patient discussion encouraging smoking cessation. At a six month follow-up, patients in the intervention group reported more quit attempts than those in the control group, and 6-month abstinence rates were 8% for the advice condition versus 4% for the control group. Among those contacted at a one-year follow-up, 8% were abstinent in the advice group as compared to 3% in the control group. Such findings illustrate the fact that physicians can positively affect patients' smoking cessation behavior. Moreover, simple advice by physicians has been shown to increase quit rates even more substantially among medically-ill patients, including those with smoking-related illnesses such as respiratory disease and myocardial infarction.

Other studies have examined the impact of brief counseling interventions by primary care physicians that encourage smoking cessation. By "brief" we mean interventions based on recommendations from the Agency for Healthcare Research and Quality (AHRQ) smoking cessation guidelines that include as little as five minutes of attention to a discussion of smoking cessation during patient appointments. The most recent study using this intervention in 1999 indicated a quit rate of 11% after a period of 9 months.

Primary care physicians and personnel have an important tool to use along with advice that also has a clear and significant impact on non-pregnant patients' quit rates - nicotine replacement therapy. Whether in patch or gum form, data support the use of this tool as an aid to advice or for more intensive counseling in helping non-pregnant smokers quit. Research shows that the combination of brief counseling and nicotine replacement therapy can produce substantial increases in quit rates. One study examined the impact of nicotine replacement therapy by general practitioners, as an adjunct to advice to quit smoking. Over 1900 cigarette smokers from six group practices in London were assigned to one of three interventions: (1) no intervention, (2) advice plus a booklet about quitting, and (3) advice, the booklet, and an offer of nicotine gum. Predictably, quit rates at four and twelve months increased as the intensity of the intervention increased, with those who were offered nicotine gum yielding the highest quit rates. Okeene and colleagues randomly assigned over 1200 pack-or-more-per-day smokers from five primary care clinics to receive one of three interventions: (1) advice only, (2) brief counseling, and (3) brief counseling plus nicotine gum. At a six month follow-up, all three groups showed encouraging quit rates: 9% in the advice only group, 12% in the brief counseling group, and 17% in the brief counseling plus nicotine gum group.

Others have similarly found that the addition of patch, gum or nasal spray to advice or counseling substantially increases quit rates. A recent large-scale review by Silagy in 1997 included 47 trials of nicotine gum, 22 of patches, 3 of intranasal spray, and 3 of nico-

tine inhaler devices. The majority of trials were carried out in primary care clinics, and most included brief advice along with the nicotine replacement therapy. The review found that among all commercially available forms, nicotine replacement therapy is effective as part of a smoking cessation strategy and produces a 2 to 3-fold increase in quit rates. Combined behavior and nicotine replacement therapy have been found to work better than either treatment by itself.

The efficacy of nicotine replacement therapy has not been established during pregnancy. Nicotine gum is an FDA category X medication (contraindicated during pregnancy); therefore pregnant women using this medication should be counseled about its use at that time. Nicotine patches are a category D drug (positive evidence of risk). Because of this risk, the use should only be considered in pregnant women who smoke over 10-15 cigarettes daily, who have made a recent but unsuccessful attempt to quit, and are motivated to quit.

The take-home message of all of this is that smoking cessation counseling does make a difference. Most smokers will make multiple attempts before quitting. The fact that brief advice makes a difference means that even though it may not seem like it, patients are listening and will continue to listen each time they see you and remember your warnings. Hopefully, many will heed your advice and decide to quit.

Smoking cessation as preconception counseling is a vital issue in primary care and women's health in the VHA. Both general and pregnancy-specific motivations are important for both smoking cessation and relapse prevention.

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The Tobacco Use Cessation Program at the Durham VAMC

Currently, about 25% of U.S. adults are smokers. The prevalence of tobacco smoking in the population of America's veterans is thought to be even greater. There is clear evidence that tobacco smoking is associated with premature death and morbidity. Evidence collected by the Centers for Disease Control suggests that about 50% of smokers will die prematurely from smoking-related illness including cancer, heart disease, stroke, and chronic obstructive lung disease. The Durham VA Medical Center has increased efforts to identify and treat nicotine addiction through full implementation of theVA/DoD Tobacco Use Cessation Clinical Practice Guidelines through its Stop Smoking Clinic.

As part of an effort to implement clinical practice guidelines, changes to the VA Medical Center's electronic medical record have been implemented. The medical record now automatically displays clinical reminders to providers to screen for tobacco use and nicotine addiction. Patients who are identified as tobacco users and who wish to quit smoking or using smokeless tobacco are referred to the Smoking Cessation Program directed by Clinical Psychologists, Loretta Braxton, Ph.D. and Patrick Calhoun, Ph.D.

Multiple factors including the dependence on cigarettes to satisfy emotional needs, strong conditioned responses that constitute the habit part of smoking, and physiological addiction to nicotine, make it very difficult for individuals to quit smoking. Because smokers tend to be hooked by emotional, behavioral, and physiological factors, we have found that interventions that simply rely on nicotine replacement are less effective than those that address the emotional and behavioral triggers associated with smoking. The current program being implemented at the Durham VAMC is one that is clinically effective, efficient and appealing to smokers. A great number of our veterans must travel a significant distance for their appointments, thus we have attempted to implement a program that is as efficient as possible without compromising efficacy. The smoking cessation program at the Durham VAMC is made up of three to four 90-minute sessions scheduled over a one-month time frame. Currently, a fourth session is being added for non-smokers interested in further addressing the issues of stress, anxiety and weight management.

During the first session, participants are given a manual that discusses various coping strategies. The majority of the session is spent reinforcing patients' decision to quit and education about nicotine fading. Nicotine fading procedures work to decrease the level of nicotine present in the body in order to reduce withdrawal symptoms. We use a brand switching procedure in which smokers switch from their current brand of cigarettes to one with less nicotine. While we could simply ask our clients to smoke fewer cigarettes in an effort to reduce their level of nicotine in preparation for their quit date, we have found that it is very difficult for smokers to give up the last one or two of their favorite cigarettes. Thus, we believe that brand switching is a more effective method of nicotine fading.

The second session is scheduled to coincide with participants' quit dates and is devoted to education about cognitive and behavioral coping methods including environmental management, the use of physical activity as a distraction, eating or drinking as a smoking substitute, and cognitive reframing among others. Participants receive education about the importance of relaxation and stress reduction and are provided with a relaxation tape. The importance of social support is discussed and efforts are made to enjoin the support of persons close to the veterans in an effort to increase their success at quitting. As part of the program, patients are evaluated by a physician and are prescribed some form of nicotine replacement, typically the nicotine patch. In the third session, participants receive counseling regarding slips, weight control, and further behavioral interventions designed to minimize feelings of deprivation. On occasion, an additional maintenance session is scheduled.

Published reports of the effectiveness of the program being implemented at the Durham VAMC have been encouraging. The 6-12 month quit rates among non-psychiatric patients are almost 50%. Quit rates among veterans with a psychiatric diagnosis are 29%. It is well documented that psychiatric co-morbidity increases the difficulty of quitting smoking. Researchers at the Durham VA are actively involved in research aimed at developing more effective interventions specifically targeted for those veterans with some form of mental illness.

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Clinical Practice Guideline Toolkits: A VA/DoD Collaboration Provider, Patient and System Implementation Tools

Donna G. Schoonover, Project Manager, St. Louis Employee Education Resource Center

The Clinical Practice Guideline Toolkits contain a variety of implementation materials for providers, patients and the system. Each toolkit is specific to a joint VA/DoD Clinical Practice Guideline. Through a collaborative process, VHA and DoD clinicians develop materials to facilitate implementation of these guidelines.

The toolkits are designed for use in clinics by multiple providers. They come packed in gym bags that weigh approximately 40 pounds. The earliest toolkits literally came in plastic toolboxes, hence the name for these educational "tools.

Although the content and available materials varies according to the specific guideline, a toolkit generally includes a notebook with a copy of the guideline, information about provider and patient education tools, an implementation manual, reference materials, and other important information. Multiple copies of provider and patient education tools are placed in the package. The provider education tools include pocket guides, key points cards specific to the guideline, exam room cards, suggested documentation forms, posters, and if available, educational videotapes and CD-ROMS on the topic. The patient education tools include patient self-management brochures and any other educational materials found to be helpful to patients such as videotapes, CD-ROMS, posters, and reminder cards.

Toolkits distributed to the VA to date include: Low Back Pain (in 2000 to staff specified by VISN Quality Management Officers (QMOs) and Clinical Management Officers (CMOs); Diabetes (in January 2001 to Chiefs of Ambulatory/Primary Care); and Tobacco Use Cessation (in September 2001 to facility education contacts). Post Deployment-Related Health Concerns and Asthma toolkits have also been distributed in January and February of 2002. A toolkit for Major Depressive Disorder will be ready in September of this year. Still in the development phase are toolkits for Postoperative Pain

Management and the Cardiovascular Guidelines.

The Education Contact at each VA facility receives the toolkit and is asked to distribute it to the appropriate service within the medical center or outpatient clinic. Currently, because of limited resources, each facility receives only one toolkit. The remaining extras are sent to the Employee Education Service (EES) distribution center and are reserved for distribution to Community Based Outpatient Clinics (CBOCs). Contact donna.schoonover@lrn.va.gov with your request for a toolkit. Quantities are limited and permission is required. At the present time, there are a few Tobacco Use Cessation and Diabetes toolkits still available.

If you wish to find out more about the Tobacco Use Cessation toolkit and other future toolkits, speak to your facility education contact. If you do not know who the "education contact" for your facility is, go to the following web address http://vaww.ees.lrn.va.gov/staff/contacts/contactlist.asp to locate the person's name and contact information.

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Using The Tobacco Cessation Toolkit In a Clinical Setting: One Medical Center's Experience

Richard Harvey PhD, Assistant Director Preventive Behavior, NCHPDP

A call came from the Education Service at our medical center, "Come and get the new- Tobacco Use Cessation Toolkit!" Upon arrival, I was presented with a large, weighty blue duffel bag. Eagerly examining its contents, to my delight I discovered a wealth of educational materials on tobacco use education. The "toolkit," a joint project between the VA and DoD, has been sent to every medical center in the VHA. (See accompanying article by Donna Schoonover).

Among the items contained in the toolkit is a comprehensive resource manual containing pertinent information about tobacco use cessation policy and clinical guidelines. Staff education materials, as well as patient education handouts, a list of relevant web sites, and reliable community agencies involved in Tobacco Use Cessation.

A number of display posters are also enclosed related to the use of smokeless tobacco. These are not as relevant for the veteran population as the ones regarding smoking. Among these is a DoD poster emphasizing that "Tobacco and Readiness for Duty" do not mix, and another stating that "Smoke-Free is Beautiful."

Several videotapes are provided in the kit. One has a number of TV anti-smoking ads, several of which could be shown on closed circuit TV in VA medical centers. Our Medical Media department has agreed to do this at our facility. Another videotape entitled "A Guide to Stop Smoking" is outstanding, and currently being shared with patients in our Smoking Cessation Clinic. An informative videotape entitled "How to Avoid Weight Gain When You Stop Smoking" is also impressive. All videos can be used successfully in either group or individual patient settings in Primary Care clinics or other venues in the medical center.

The provider reference and pocket cards contain important information on TUC clinical practice guidelines. These were distributed to primary care clinicians at our center to assist in motivating patients to stop smoking. The cards reinforce staff education and offer many helpful hints. A tobacco diary is an effective tool for patients in their effort to quit; and is also available.

Two CDs come with the toolkit. The evidence-based medicine one is intended for providers but does not deal directly with smoking cessation. The second describes a U.S. Navy primary care smoking cessation program and includes provider and patient education materials.

The brochures found in the kit are exceptional and can be useful as part of a display at annual hospital wellness fairs. There is also a copy of "STOP!" a publication intended for persons who have decided to stop using tobacco.

Overall, there are many helpful educational materials in the toolkit that could be beneficial to a smoking cessation coordinator at a facility. Various handouts, pocket cards, brochures, and videos can be used to convince patients that they should consider stopping smoking. The staff education materials can supplement and strengthen these efforts. Finally, several of the brochures as well as some of the posters are good for enhancing public awareness of this problem.

The kit is an invaluable resource in the VHA's efforts to reduce smoking prevalence among veteran patients. Providers and patients alike anticipate the development of other toolkits by the collaborative efforts of VA and DoD that will enhance health care delivery in the VHA.

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Motivating Veterans To Better Health:

An Example of Librarian and Clinician Teamwork

Janet Schneider, MA, James A. Haley Veterans Hospital

Patient health education has become increasingly important in VA hospitals as JCAHO standards, customer satisfaction surveys, shared-decision making and informed consent practices highlight the integral part that patient education plays in quality medical care and prevention. Changes in health care practice have placed greater responsibility on patients to follow prescribed treatments and improve health behavior. In order for this to happen however, the patient must first comprehend, remember, and act on learned health information that will result in better health. Yet most patients retain very little of the information that is discussed during an actual clinic visit. Printed information, written in language understandable to the general population, can assist in this process. With the enormous volume of patients seen in VA facilities each day however, it can be difficult for clinicians to link each patient to the pertinent and reliable health information that meets his or her needs.

Librarians at the James A. Haley Veterans' Hospital in Tampa, Florida recognized the need for patient education materials to be housed in a centralized, accessible location. In the late 1970s, staff began the transition of the Patients' Library from a strictly recreational materials collection to a diverse gathering of current, authoritative health information resources. Today the Patients' Library has evolved into an inter-active, consumer-focused health information Center with a full-time professional Patient Education Librarian. The center recorded over 41,000 visits in fiscal year 2001, with frequent patient and family referrals from clinicians as well as self-referrals from veterans, families, visitors and health care staff.

O. B. Donaldson, veteran, using the Health Reference Center database

It was decided early in the transition to retain the name "Patients' Library" for the Center. When selected veterans were polled about their choice for a name (e.g. Library, Patient Education Resource Center, Learning Resource Center, etc.), the word "Library" was almost universally favored. One veteran expressed the feeling of many when he told library staff that he was "too old" for further education-as he proceeded to read the health information he had just requested.

Gil Castillo, veteran, looking at health information books

The services of the professional Librarians are critical to the success and use of Tampa's Patients' Library. Information resources have blossomed from the somewhat limited selection of consumer health books available in the 1970s to a massive explosion of print and audiovisual materials, electronic databases, and the Internet. The discerning eyes of the experienced health science Librarians identify and provide current, authoritative resources to ensure that veterans receive accurate health information at an appropriate reading level, manage library resources for ease of use, and link patrons to the correct information.

Library staff, several years ago, developed "Health Information Request" prescription pads after a cheerful "newly diagnosed" patient was sent to the Patients' Library requesting information on lymphoma. After careful questioning, it became apparent that the symptoms the gentleman was describing did not match his reported diagnosis. A call to the patient's nurse confirmed the librarian's concern: the patient's actual diagnosis was a lipoma. Use of the prescription pads eliminates misunderstandings of medical words, and also gives the librarian enough data (name and SSN) to document the information encounter in the electronic record. Any questions or concerns voiced to the librarian by the patient are also noted, so that the clinicians or therapists are aware of them. For example, the veteran with colitis, who wanted to know what he could eat, plainly needed more nutrition reinforcement, as he was overheard telling his wife that he was headed to the cafeteria for coffee and pizza.

O.B. Donaldson using the Health Reference Center database, while Gil Castillo peruses health information books

Speed in delivering the information to patients and staff is a top priority in the Center. Patrons who come to the library generally have their information in 15 minutes or less; complex requests may take longer, but are usually completed within 24 hours. Reprints of materials are given to each patient, so that the veteran can take the information to his or her health care provider for discussion. Requests also arrive by telephone and e-mail. Delivery methods include faxing or hand carrying to health care providers' offices, mailing to veterans' homes, delivery to inpatient units, and pick-up in the Patients' Library.

To make handouts more accessible at the point of care, librarians located consumer health public domain documents from the National Institutes of Health and other government agencies. These were downloaded and mounted on the hospital's computer network service drive, a shared electronic location that is available to all clinicians from their desktops. These materials are also being added to the hospital's Intranet web page. Other sources of patient health education have been provided, as well. For example, Library Service has made available to VA clinicians at the Tampa hospital and outlying outpatient clinics, MD Consult, a comprehensive web-based tool for clinical online resources including nearly 3,000 customizable patient education handouts. Additionally, the Health Reference Center full-text consumer health database is available

for both patients and clinicians to search either at a computer work station in the Library or via the hospital's Internet access. Finally, the librarians and patients obtain excellent information on the diagnosis, prevention, and treatment of a variety of medical conditions from MEDLINE Plus (http://www.medlineplus.gov), the National Library of Medicine's consumer health database, and other reliable Internet sites.

Other services and resources have evolved from staff and veterans' needs:

- With the support of the hospital's interdisciplinary Patient Health Education (PHE) Committee, a pamphlet entitled "Teamwork: Be Your Health Care Provider's Partner" was developed by the Patient Education Librarian to help patients prepare for their clinic visits and learn to better communicate with their health care providers. A wallet medical guide, for patients to note their health histories and medicines, was also developed with the blessing of the PHE Committee.
- The Patient Education Librarian is frequently invited to speak to veterans' groups, such as POWs, diabetics, and visually impaired vets, on finding reliable health information, available resources, and the patient's role in the health care process (learning about one's health, asking questions, sharing in the decision-making process, etc.)
- Librarians run the popular On-Demand closed-circuit television (CCTV) system for the hospital, providing staff and patient video education from a central location. Patients may view videos in their rooms as inpatients, or in the library and clinic areas as outpatients.
- A health information newsletter, which was initiated by Library Service and the local PHE Committee, has evolved into a VISN 8 project sponsored by the Network's Patient Education Work Group. Published quarterly and edited by Tampa's Patient Education Librarian, the Sunshine HealthNet is distributed to all VA hospitals and outpatient clinics in Florida and Puerto Rico. It highlights preventive medicine and other health information topics.
- As an active member of the PHE Committee, the Patient Education Librarian takes a proactive role in facilitating access to needed education resources, and chairs the Resources Subcommittee for purchase of PHE materials for Tampa VA educators.

Feedback from staff and veterans about services and resources is extremely positive.

Comments from patients include:

- "Thank you very much! I am very nervous about my upcoming operation, and the info and the staff at the Patients' Library helped me. Now I am informed and at a lot better level (information wise) to deal with this."
- "Thank you so much for being here. It's so much easier to face a disease when you can understand and get information about it. Bless you."
- "By researching my medical problems on the computer before seeing my doctor, I was able to engage in a more satisfactory dialog with her. The knowledge I brought with me reduced the time my doctor had to spend in explanations."

Comments from the staff were equally positive:

- "I could not provide health education for our patients without the librarian."
- "She (the librarian) is so willing to assist staff in providing educational information for our patients. She always comes through even when given short notice. Goes the extra mile and provides additional information that she feels patients/staff can use."
- "She (the librarian) believes in giving accurate and current information to our patients."

Tampa's veteran patients are provided the tools they need to take responsibility for their own health (talking to health care providers, researching health information through reliable sources, asking questions and voicing concerns, and sharing in the decision making process.) The partnership between Tampa's clinicians and professional health sciences library staff enhances the quality of medical care, patient satisfaction with the hospital, and the health potential of our veterans.

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Author's Note: "Here at the Tampa VA, we believe that prevention is the key to better health for all veterans. Much of the information we provide is on preventive medicine: controlling cholesterol in the diet, obtaining necessary flu shots, diabetes control, weight management and nutrition, etc. The consumer health resources we provide reinforce the clinicians' recommendations for better health and are designed to give the veterans and their families the information they need to share in the decision-making process."

VA Community Center with Wellness, Education and Child Care Facilities, Turning Heads Among Other VA Facilities Nationwide

Vicki Timpa, RN, MS, VA North Texas Health Care System

Employee wellness and education at Dallas VA Medical Center (VAMC) received a big round of applause in June 1999 with the opening of a 15,608 square-foot community center. Numerous comments from VA facilities nationwide and local health care facilities acknowledged Dallas VAMC for inspirational leadership as having a vision that sparked interest for opening other centers.

Built as part of a multi-use educational center, wellness center, and child care center, the VA Community Center makes Dallas VAMC a leader within the Department of Veterans Affairs in promoting wellness and educational events.

The multi-use facility is located on the northwest corner of the 84-acre campus and was built as a joint effort by VA North Texas Health Care System (VANTHCS), City of Dallas, and Dallas Area Rapid Transit (DART). Alan G. Harper, Director, said, "I envisioned this as an opportunity for VANTHCS and the community to join together for unity in education, wellness, and childcare." Mr. Harper's leadership, vision, and ability to bring the community together, produced the VA Community Center that is a stone's throw away from the Dart Rail line connecting the community to Dallas VAMC.

"Helping our employees stay physically fit will help boost morale and productivity," said Employee Wellness Coordinator Tina Eudy. "We hope these employees will set an example for others". A mandatory thirty-minute orientation and health screening session is required prior to use of the Wellness Center, which features free weights, machine weights, cardiovascular equipment, and group exercise room. Participants have full use of showers, lockers, and restrooms, so a quick workout can be accomplished before and after work or during lunch.

Hours of operation are
6:00 a.m. - 8:00 p.m., Monday through Thursday with group classes available on these days. Group exercise classes have become a big hit, according to Eudy, in addition to single use of approximately 45 people per day. On Fridays, there are no group classes, and hours of operation are 6:00 a.m. - 6:00 p.m.

The Wellness Center is available to all VANTHCS employees and their spouses, as well as outpatient veterans and their spouses, for a nominal fee of $5 every two weeks per person. An added value contract with the Dallas Urban League allows community participation in the Center. World Instructor Training Schools are also contracted to provide education and personal fitness training with certification.

As a major part of the VA Community Center, the Education facility includes a 100-person capacity conference room which can be partitioned into three separate rooms for use by VA staff as well as the community. This area is usually reserved each weekday as well as evenings, according to Christina Frias, RN, MS, Clinical Education Coordinator. "The Community Center offers flexibility in the number and types of programs available to our employees," said Gail Bentley, PhD, Associate Chief of Staff for Education. Dr. Bentley has provided multiple on site opportunities for employee training and upward mobility. Cedar Valley Community College and Mary-Hardin Baylor offer college courses to employees after hours so they can work toward a degree of higher education.

The Child Care facility of the VA Community Center was activated in the fall of 2000, under the direction of Dan Lake, PhD. Dr. Lake currently has 30 children enrolled with capacity for 80. Hours of operation are 6:00 a.m. - 6:00 p.m. Monday through Friday. The cost incurred for each child is based on age. Tuition subsidy is also available.

Vicki Timpa, RN, MS
Patient Health Education Coordinator
VA North Texas Health Care System
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Worth-noting

Obesity Counseling Strategies for Health Care Providers

Since mid-February, the online program with this title has been available on the Southwest Health Professions Education Center website http://www.sweducationcenter.org

The VA HIV Prevention Handbook: A Guide for Clinicians (New HIV Prevention Resource) Kim W. Hamlett-Berry, Ph.D., Director, HIV and Hepatitis C Prevention Service, VA Public Health Strategic Health Care Group, VACO

The HIV and Hepatitis C Prevention Program of the VA Public Health Strategic Health Care Group is pleased to announce the release of a new HIV prevention resource, The VA HIV Prevention Handbook: A Guide for Clinicians. The Handbook provides practical information and guidance on HIV prevention for veteran populations at-risk and those with HIV. Information is included on how to evaluate risk for HIV, how to bring up issues such as HIV testing and risk reduction, and strategies on how to use a wide variety of HIV prevention interventions. Clinical information is provided on prevention issues and strategies appropriate to meet the needs of patient populations seen in the VA Health Care System. In addition, information about relevant VHA Information Letters and Directives is also provided. Copies of the Handbook have been distributed to VA HIV coordinators, Medical Center Directors, Substance Abuse Treatment Program Directors, Team Leaders of Vet Centers, and CBOC Directors.

Copies should be available for order through the VA Publications Depot. To order copies through the Depot please contact the Forms and Publications Control Officer at your facility and request that they place an order for you. The IB Number for the Handbook is 10-91 and the P Number is P95644. (In order to check the availability of the Handbook at the Depot, you may want to have the Forms and Publications Officer at your station check FPORDERS to see if it has arrived.) If you do not know the name of your local VHA Forms and Publications Control Officer, you can look them up on the website http://vaww.va.gov/vhacio/comm/index.cfm. Click on the heading 'Forms and Publications Officers' on the blue side bar on the left side of the page. You can then call or email that contact person and ask them to look up the Handbook in their catalog and order additional copies for you. If you have additional questions about HIV prevention, please contact Kim Hamlett-Berry, Ph.D., Director, HIV and HCV Prevention Service, Public Health Strategic Healthcare Group, Department of Veterans Affairs, 810 Vermont Ave., NW, Washington, DC 20420. Office (202) 273-8929; Fax (202) 273-6243; kim.hamlett@hq.med.va.gov

HIV/AIDS NEWS SERVICE
Michael Howe, MSLS, Editor
Director, AIDS Information Center
Public Health Strategic Health Care Group

Water Fluoridation-Cost Effective Prevention

Research into the beneficial affects of fluoride began in the early 1900's. A young dentist, Frederick McKay, opened a practice in Colorado Springs, Colorado and noted that many local residents exhibited brown staining on their permanent teeth. After consulting with G.V. Black, an expert on tooth enamel, the condition was described to be mottled enamel or dental fluorosis. They also noted that the stained teeth were extremely resistant to decay. Following years of observation and study, McKay determined that high levels of fluoride occurring in the drinking water were causing the mottled condition.

Trendly Dean, a dental officer with the U.S. Public Health Service, researched and designed the first fluoridation studies in the United States. By 1936, Dr. Dean and his staff determined that fluoride levels of 1.0 parts per million (ppm) did not cause mottling or flurosis but did note that there was a correlation between fluoride levels in water and reduced incidence of dental decay. Following this, community wide studies were conducted with the addition of sodium fluoride to fluoride-deficient water supplies. The first community water fluoridation program began in Grand Rapids, Michigan in 1945.

The United States now has over 50 years of practical experience with community water fluoridation. This period of longevity indicates fluoridation's significance as a public health measure. Some important points about fluoride and community water fluoridation should be noted:

- Fluoride helps prevent tooth decay. Recommended fluoride levels for optimal decay prevention is 0.7-1.2 ppm.
- Fluoridation benefits children and adults. Simply by drinking water, community members benefit regardless of age, socioeconomic status, educational attainment or ethnicity regardless of their access to dental care.
- Fluoridation protects over 360 million people in 60 countries worldwide, with over 145 million people in the United States.
- Fluoride is safe and effective when used and consumed properly. After over 50 years of research and practical experience, scientific evidence indicates that fluoridation of community water supplies is both safe and effective.
- Just 50 cents per person per year covers the cost of fluoridation in an average community. Over a lifetime, this is approximately the cost of one dental restoration, making fluoridation very cost effective.

Water fluoridation and topical fluorides have made a dramatic impact on oral health. Studies show that water fluoridation can reduce the amount of decay in primary teeth in children by 60% and in permanent dentition in adults by 35%. Increasing numbers of adults are retaining their teeth throughout life due in large part from water fluoridation. Although only 62% of the U.S. population is on

fluoridated public water supplies, dental expenditures for theses individuals have been reduced and needless pain and suffering due to untreated dental decay have been avoided.

Dental decay as a disease entity can be prevented and the dental community has done much to promote prevention. As health care professionals we must strive to totally eliminate dental decay. Fluoridation plays a major role and has been shown to be cost effective and safe. Our work is not done however until we ensure that everyone has the opportunity to experience the benefits of this most important preventive adjunct.

C. Richard Buchanan, DMD, FICD
Deputy Director, Dentistry
VACO, Washington DC

HEALTHY HAPPENINGS

The following information can also be found on the NCHPDP website at vaww.nchpdp.med.va.gov

September

Cold and Flu Campaign
American Lung Association
(800) LUNG-USA
www.lungusa.org
Contact: Nancy Cease

Gynecologic Cancer Awareness Month
Gynecologic Cancer Foundation
(800) 444-4441
www.wcn.org
Contact: Karen Carlson

Healthy Aging Month
Educational Television Network, Inc.
(610) 793-0979
www.healthyaging.net
Contact: Carolyn Worthington

National Cholesterol Education Month
National Heart, Lung, and Blood Institute Information Center
(301) 592-8573
www.nhlbi.nih.gov
Contact: Information Specialist

Ovarian Cancer Awareness Month
National Ovarian Cancer Coalition, Inc.
(888) OVARIAN
www.ovarian.org
Contact: Tina Grekin

Prostate Cancer Awareness Month
National Prostate Cancer Coalition
(888) 245-9455
info@pcacoalition.org
Contact: Community Liaison

National 5 A Day Week (9-15)
National Cancer Institute/Produce for Better Health Foundation
(800) 4-CANCER
www.5aday.gov
Contact: NCI 5-A-Day Program Office

Family Health and Fitness Days USA (29-30)
Health Information Resource Center
(800) 828-8225
www.fitnessday.com/family
Contact: Pat Henze

October

Healthy Lung Month
American Lung Association
(800) LUNG-USA
www.lungusa.org
Contact: Communications Department

National Breast Cancer Awareness Month
National Breast Cancer Awareness Month Board of Sponsors
www.nbcam.org
Contact: B.J. Iacino

Mental Illness Awareness Month (6-12)
American Psychiatric Association
(888) 357-7924
www.psych.org
Contact: Answer Center

National Depression Screening Day (10)
National Mental Illness Screening Project
(781) 239-0071
www.mentalhealthscreening.org

National Adult Immunization Awareness Week (13-19)
National Coalition for Adult Immunization
(301) 656-0003
www.nfid.org/ncia
Contact: David A. Neumann, Ph.D.

National Mammography Day (17)
American Cancer Society
(800) ACS-2345
www.cancer.org

National Health Education Week (21-27)
National Center for Health Education
(212) 594-8001
www.nche.org
Contact: Roz Coralle

November

American Diabetes Month
American Diabetes Association
(800) 232-3472
www.diabetes.org
Contact: Local Chapters or National Office

National Alzheimer's Disease Awareness Month
Alzheimer's Disease and Related Disorders Association
(800) 272-3900
www.alz.org
Contact: Local Chapters or National Chapter

National Hospice Month
National Hospice and Palliative Care Organization
(703) 837-1500
www.nhpco.org
Contact: Jon Millet

Great American Smokeout (21)
American Cancer Society,
National Headquarters
(800) ACS-2345
www.cancer.org
Contact: National Office

December

National Drunk and Drugged Driving (3D) Prevention Month
3D Prevention Month Coalition
(202) 452-6004
www.3dmonth.org
Contact: John Moulden

World AIDS Day
American Association for World Health
(202) 466-5883
www.aawhworldhealth.org
Contact: Staff

Susi K. Lewis, MA, RN, CPHQ
Assistant Director, Field Operations
VA National Center for Health Promotion and Disease Prevention
(919) 383-7874 ext. 234 Fax (919) 383-7598

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Putting Prevention Into Practice in the VA

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